EDITORIALS

Perspective on Primary Care

TWO VERY DIFFERENT ARTICLES in this issue address the subject of family practice and primary care. One is more conceptual and distinguishes among family practice, family medicine and family health care. The other is more pragmatic and tells how a community hospital can establish a family practice residency with a firm root in a university center. Both deal with training physicians in a new specialty to provide a new kind of service in something called primary care. But there is as yet no clear agreement about just what is involved in family practice, family medicine, family health care or primary care for that matter. An effort, though perhaps a feeble one, to put things in perspective seems in order.

In the nostalgic days of the horse and buggy doctors in primarily rural America, medical care indeed focused upon the family and upon the caring function. There was then relatively little of scientific worth in the doctor's head or in his bag. As medical science advanced in the 1920's, 1930's and especially in the 1940's and 1950's, attention turned to curing, and most physicians became specialists or subspecialists; this has continued. There was less attention to the whole patient, or to fulfilling most of the needs for care at one stop, so to speak. General practice began to dwindle in both prestige and numbers. In the 1960's the family practice "movement" began. The illusion spread that specialists do not take care of families or of the whole patient, though many did and still do. The formal transformation of general practice into the new specialty of family practice was accomplished. Political pressures developed to train doctors to do primary care, and family practice has ridden the crest of this wave for a decade. And in the last few years the movement has had a strong assist from today's more socially conscious medical students who have sought in large numbers to enter family practice and to provide primary care.

Though neither term is presently well defined, family practice does not seem to equate with primary care. Both terms tend to mean whatever a proponent thinks they should mean. To some, primary care means the first stop at entry into the health care system. Others believe it means care of the majority of ills the flesh is heir to with referral to specialists as necessary. Yet others see it primarily as the prevention of illness and promotion of health, with some aspects of what is coming to be called holistic medicine. And there are also some who do equate primary care with family practice. The proponents of family practice have had some difficulty with the word "family," since a substantial amount of the primary care they believe they should do as family physicians really does not significantly involve the patient's family, and there are a significant number of patients whose family ties are nebulous to say the least. It has been suggested that family be redefined as any group with a past and a future, in an effort to deal with this problem.

The articles in this issue both address training for family practice physicians. Gerber and Massad point out that two distinct kinds of primary care physicians are now being trained. One is chiefly university-based in the traditional disciplines of internal medicine and pediatrics but with substantial emphasis on primary care in the ambulatory care setting, while the other is chiefly community hospital-based for training with more emphasis on the special character of family medicine, which they describe as:

> a theoretical perspective and a body of knowledge with potential application to any medical practice. It places the patient in the context of his environment, puts the medical intervention into a broader perspective, and expands the diagnostic and therapeutic possibilities of the physician to include the impact of the family on the disease process and the impact of the therapy on the patient's support system.

They also emphasize that this approach is as valid for a surgical subspecialist as it is for a primary care physician. Werblun and Martin describe the development of a family practice residency program which seeks to gain some of the advantages of training in both the university and community hospital settings and thereby try to have the best of both worlds.

There are many unanswered questions in this burgeoning field of primary care, which embraces much that is new and much that remains the same. There is obviously much experimentation going on everywhere. The reemergence of a formal focus on caring for the whole patient can only be good,

as is the renewed emphasis on one stop care for many common, uncomplicated, everyday patient care problems. There are dangers that some physicians trained to do only primary care will be tempted to go beyond what should be their limits, and there are dangers that family practice itself will become so enamored of family medicine that the essential grounding in traditional disciplines may be too greatly weakened to the detriment of quality in the care of sick patients. Very recently a major study by the Institute of Medicine of the National Academy of Sciences reminded us that it is the services and not the specialty that should form any definition of primary care, and spelled out the attributes that are essential to the practice of good primary care. This may help to develop a framework for discussing some of these problems and for answering some of the questions that need to be answered.

—MSMW

Hemoptysis 1977

DR. H. LYONS aptly stated recently, "The causes of hemoptysis vary in incidence from series to series and a number of factors influence the frequency in a particular report."[1] In this issue of the WESTERN JOURNAL, Drs. Wolfe and Simmons have expertly reviewed the causes and the factors related to hemoptysis. They also have discussed the management of hemoptysis, in particular the somewhat controversial topic of management of massive hemoptysis. In so doing they have compiled an excellent reference list 62 articles long. Their five tables actually serve as a fine outline for a clear and succinct approach to the problem.

In the 1970's several evolving trends concerning hemoptysis must be stressed, however. Certainly the true incidence of massive hemoptysis (arbitrarily defined as a rate of expectorated blood in ml per 24 hours—most authors use a minimum of 200 ml per 24 hours to define massive) has decreased. The better control of major lung infections causing massive hemoptysis (such as tuberculosis, active and arrested; bronchiectasis; lung abscesses, and necrotizing pneumonia) is the obvious explanation for this fortunate improvement. Specifically, at a busy city-county hospital of 350 beds and a large tuberculosis clinic, I cannot remember a single death due to massive hemoptysis from the aforementioned causes during the 6½ years I have been chief of the medical pulmonary services. This I must admit is probably an unusual, if not an atypical, experience, but still reflects the trends of the 1970's. During this same period we have worked closely with the thoracic surgery service and together have seen approximately two cases per year of massive hemoptysis requiring emergent aggressive thoracotomy and pulmonary resection. During this period I have also seen approximately four to five cases per year of frank hemoptysis (more than "streaking" but less than massive) in patients with a history of previously active tuberculosis. Unless the patients with this past history of tuberculosis and now current hemoptysis have some new active process (such as (1) reactivation of their tuberculosis—very rare, (2) actively infected cysts or residual cavities both by bacterial and aspergillosis—common, or (3) carcinoma—occasional), the hemoptysis was always of short duration and benign. This latter experience of hemoptysis in patients with arrested tuberculosis concurs strikingly with a larger published series by Stinghe.[2] He showed such patients' bleeding is from residual tuberculous bronchiectasis and also uniformly has a self-limited benign course.

The incidence of the two lung diseases, bronchitis and bronchial carcinoma, which usually cause nonmassive hemoptysis is increasing. In regard to this latter group of patients with nonmassive hemoptysis, the primary physician is often faced with the decision of recommending bronchoscopy or not. Since chronic bronchitis and bronchial carcinoma often coexist in the same population, there is no easy or single correct answer to this question. I strongly concur with Drs. Wolfe and Simmons' statement: "In many cases of nonmassive hemoptysis, the cause is obvious and bronchoscopy is not necessary." Several clinical guidelines are helpful, however, in this group where the hemoptysis is usually "streaking of sputum." If the patient is less than 35 years old or is a nonsmoker, the likelihood of primary bronchial cancer is rare. In addition, in the great majority of bronchitic patients findings on radiographs of the chest are normal (excluding hyperinflation and mild increased markings), while in most patients with bronchial cancer with hemoptysis there are abnormal findings on films (mass, infiltrate, atelectasis and the like). Also it is important to remember that blood streaking of sputum secondarily to an acute bronchitis or an exacerbation of chronic bronchitis usually lasts only a day or two, while persistence or recurrence of such blood-streaked sputum or cough is much